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Frank Frasier

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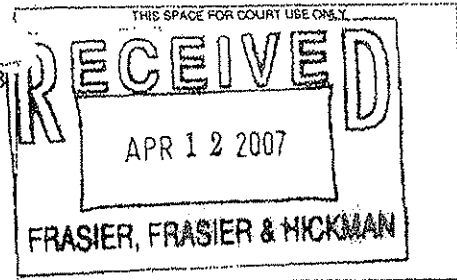
**FORM 10**

Send original to  
Workers' Compensation Court and 1 copy to  
Claimant or the Claimant's Attorney of  
Record

## WORKERS' COMPENSATION COURT

1915 NORTH STILES

OKLAHOMA CITY, OKLAHOMA 73105-4918



In re claim of:

Full Name of Injured Employee (Claimant) <b>ELIAZAR TORRES - GOMEZ (DECEASED)</b> <b>AMALIA DIAZ - CLAIMANT</b>
Claimant's Social Security Number <b>584-41-0756</b>
Name of Employer (Respondent) <b>CINTAS</b>
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured <b>OWN RISK</b>

## ANSWER AND PRETRIAL STIPULATION OFFERED BY RESPONDENT

FILE NO. <b>2007-03253A</b>
Date of Injury <b>3-6-07</b>

**NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or In-state toll free (800) 522-8210.**

YES NO (Please Type or Print)

- X 1. Was claimant at the time of the alleged injury, an employee of the above named respondent?
- X 2. Was claimant covered by the Workers' Compensation Act?
- X 3. Did claimant sustain an accidental injury or suffer an occupational disease arising out of and in the course of the employment?
- X 4. Has claimant filed a Form 3 within the statutory period of time?
- X 5. Did respondent, at the time of the alleged injury, have an own-risk permit or a compensation insurance policy with the carrier named in the caption above?
- X 6. Did claimant timely notify respondent of the injury?
- N/A 7. If not, does respondent allege prejudice by such failure?
- N/A 8. Has claimant been provided medical treatment?
- N/A 9. Has respondent commenced payment of temporary total disability payments to claimant?
- Temporary total disability has been paid to claimant from \_\_\_\_\_ to \_\_\_\_\_ for a total of \_\_\_\_\_ weeks in the total sum of \$ \_\_\_\_\_.

(ALL DEPOSITIONS OF MEDICAL EXPERTS SHALL BE COMPLETED PRIOR TO TRIAL)

- X 10. Is rate an issue? Claimant's compensation rate: TTD TO BE DETERMINED PPD TO BE DETERMINED
11. State all affirmative defenses: RESPONDENT DENIES ACCIDENTAL INJURY AND DEATH BENEFITS PENDING INVESTIGATION.
12. List the names of all witnesses who may be called by respondent at trial: TO BE DETERMINED
13. List all exhibits to be introduced at trial: TO BE DETERMINED
14. Respondent hereby certifies that a copy of the medical report written by Dr. TO BE DETERMINED and dated \_\_\_\_\_ was mailed, together with a copy of this motion to Opposing party/Counsel.

(LIST ON A SEPARATE SHEET, ADDITIONAL WITNESSES, EXHIBITS AND MEDICAL EVIDENCE)

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Signed this 11th day of APRIL, 2007

Opposing Party <b>J. L. FRANKS / FRANK FRASIER</b>		
Address (Number & Street) <b>P.O. Box 799</b>		
City <b>TULSA, OK.</b>	State <b>OK.</b>	Zip Code <b>74101-0799</b>

Signature of Filing Party <b>Steven K. Bunting</b>		
Address (Number & Street) <b>15 WEST 6TH STREET, SUITE 2704</b>		
City <b>TULSA, OK.</b>	State <b>OK.</b>	Zip Code <b>74119</b>
Telephone # of Filing Party <b>(918) 592-7030</b>		
Print or type name of Attorney <b>STEVEN K. BUNTING</b>		OBA # <b>#1311</b>

